TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS ALLIANCE MEDICAL GROUP

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-0309-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 05, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement received from the requestor.

Amount in Dispute: $7,377.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute 3/25/2013 to 7/25/2014.

1. TEXAS ALLIANCE MEDICAL GROUP PA provided services to the claimant on the date above …
4. One year from disputed date 7/25/14 is 7/25/15. The TDI/DWC date stamp lists the received date as 10/2/15 on the requestor's DWC-60 packet, a date greater than one year from 7/25/14. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Company 6210 E HWY 290 Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2013 to June 18, 2014	CPT Codes 97110, 97140, 99213, 99080, 99214 and G0283	$8,013.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets forth general medical provisions regarding dispute of medical bills.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- CAC-219 – Based on extent of injury
- 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place
- CAC-W1 – Workers Compensation state fee schedule adjustment
- CAC-219 – Based on extent of injury
- 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions. Reimbursement denied per Rule 129.5
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure has already been adjudicated
- 284 – No allowance was recommended as this procedure has a medicare status of "B" (Bundled)
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration of services for information call 1-800-934-6824
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   (B) A request may be filed later than one year after the date(s) of service if:

   (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

   The date of the services in dispute is March 25, 2013 to June 18, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 05, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services involves issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/23/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.